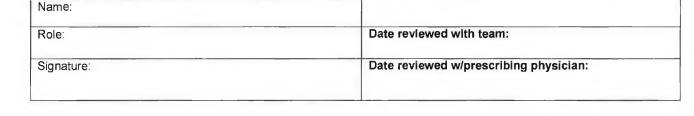
## BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION PART ONE: HEALTH SERVICES REPORT

(To be completed by	agency/residential	program specialist) prior to psycho	tropic medication		
INDIVIDUAL:			DATE-PSYCHOTROPIC MED REVIEW:		
ADDRESS:			PREVIOUS REVIEW:		
DATE OF BIRTH:			PHYSICIAN'S NAME:		
CARECO CONTACT:			OFFICE ADDRESS:		
CONTACT PHONE:			OFFICE PHONE:		
CURRENT MEDICATIONS (Please list all medications, including over-the-counter, dietary supplements, etc.					
Attach additional pages if necessary. Include the individual's name and date of review on every page.)					
MEDICATION NAME	DOSAGE	FREQUENCY	Reason for Admi	nistration	
	05 001198 1 11181	ALTER HERIOA			
ARE THERE ALLERGIES OR CONTRA-INDICATED MEDICATIONS? □ NO∜⊕ YES If "YES," Specify and describe all symptoms:					
HAS THIS DIAGNOSIS	S THIS DIAGNOSIS DIAGNOSIS (5-Axis Diagnosis			TARGET SYMPTOMS (BEHAVIORAL	
CHANGED? SEE PAGE	from a physician, as		DESCRIPTION) Target Symptoms listed here must		
3 and check if updated:	documented in medical records)		match those listed on Part 2		
AXISI					
(MH Diagnosis)					
AXIS I (2)					
AXIS II					
(MR Diagnosis)					
AXIS II (Personality					
Disorder)					
AXIS III			<u> </u>		
(All Medical Diagnoses)					
AXIS IV (Psychosocial Stressors): as documented by physician/medical records. Notify physician if new					
issues/changes. Check all that apply:					
			access to health care services 🗁 🗁		
□□□ Problems related to the social environment □□□ Occupational problems					
□□ Educational problems □□ Problems related to the judicial system					
Other psychosocial/environmental problems					
AXIS V (Global Assessment of Functioning/GAF) Score (0-100) (Score provided by physician per DSM scale)					
Last Tardive Dyskinesia S		/IS test):	date and result - required ever	y 6 months)	
(Include Score:	Date				
CURRENT HEALTH STATUS/MEDICAL ISSUES OF NOTE (Attach significant lab and diagnostic study results):					
CHECK all items that were an issue since the last psychotropic medication review. Add comments whenever					
possible.					
Image: Street of the continence to					
♦ congestion       ♦ diarrhea       ♦ emenstrual change					
COMMENTS OR SYMPTOMS NOT INCLUDED IN ABOVE LIST: (Please describe)					
Printed name and signature(s) indicating prior psychotropic medication review reports were reviewed in preparing this report.					
Completed by: (Printed Na	me and Signature)		Title:	Date Signed:	
Completed by. (Finted Na	me and dignalate)	•	1100.	Date Orgined.	
Agency Nurse Review: (Pi	rinted Name & Sigr	nature):	Title:	Date Signed:	



## BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

PART TWO: BEHAVIOR SUPPORT TREATMENT REPORT (To be completed by monitoring team member [behavior specialist, QMRP, program specialist, family member] prior to review.) DATE-PSYCHOTROPIC MED REVIEW: INDIVIDUAL: TARGET SYMPTOMS BEING DOCUMENTED Include BEHAVIORAL DESCRIPTIONS of Target Symptoms for each mental health diagnosis listed on Axis1 on Part 1 of this form. Behavioral descriptions must be specific to the individual. For each target symptom, fill in the number of occurrences for the past month. Additional charts/graphs may be attached. Add comments wherever possible. Month's Data Target Symptoms (from Part Comments Fill in frequency of each symptom Wk1 Wk2 Wk3 Wk4 1) BEHAVIORAL DESCRIPTION 1) 2) 3) 4) 5) ADDITIONAL CONCERNS SINCE LAST REVIEW Check any symptoms or environmental changes not being documented above that have appeared since the last review (clarify in Additional Comments section below) Obsessive-Compulsive Behavior □ Activity Level (increased or decreased) □ ☐ Unusual Body Movements (i.e., tremors) Sleep Changes Other (Specify: Anxiety Appetite (Increased or decreased) Suicidal Ideation/Behavior None Change in Mood Environmental Issues  $\Box$ Psychotic Symptoms Were there any incidents related to the individual's behavioral health diagnosis or target symptoms? Check the box if so, and insert number of occurrences. . Psychiatric Hospitalizations? ⇒ER visits? ... Restraints? ADDITIONAL COMMENTS Signature(s) indicate that prior psychotropic medication review reports were reviewed in preparing this report. This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY



Date form completed:



30 DAYS MINIMUM.

SUMMARY COMPLETED BY:

Appendix 8 BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION PART THREE: PHYSICIAN'S REPORT (To be completed by physician prescribing psychotropic medication INDIVIDUAL: DATE OF PRESENT PSYCH MED REVIEW: DATE OF NEXT PSYCH MED REVIEW: PHYSICIAN'S AGREEMENT WITH CURRENT DIAGNOSES AND TARGET SYMPTOMS: (see Page 1 and Do the diagnos(es) in Part 1 and the target symptoms in Part 2 remain as indicated on Part 1: Health Services Report and Part 2: Behavior Support Treatment Report? ... Yes ... No If NO, please change to: TREATMENT GOALS (Regarding Target Symptoms **PROGRESS TOWARD GOALS:** listed on Parts 1 and 2): Psychotropic medications are necessary? Yes Psychotropic medication dosages are within usual range? Yes□ No Number of drugs conforms to accepted standards? Yes 🗍 No **P** Are medication side-effects present? (i.e., sedation, ataxia, dyscrasia) No Yes□ Screening test performed (i.e., AIMS)? Yes 🗆 No 0 Symptoms of T.D. or other E.P.S.? Yes Yes Medication reduction/titration plan considered? PHYSICIAN'S ORDERS MEDICATION CHANGE: NO YES (provide information below) NEW MEDICATION (List medication, dosage & frequency) **REASON FOR NEW MEDICATION** Medication Education Provided? ♥Yes □No Medication Dosage Frequency 1) 2) 3) MEDICATION CHANGE (List med. dosage & frequency) REASON FOR MEDICATION Medication Dosage Frequency **CHANGE Medication Education Provided?** 1) 2) 3) REASON FOR MEDICATION MEDICATION DISCONTINUED (List med dose, frequency) **DISCONTINUATION Medication Education** Medication Frequency Dosage Provided? TYes ☐No 1) 2) LAB STUDIES, DIAGNOSTIC TESTS AND FREQUENCIES: Metabolic screening done? TYes Do Date:\_ COMMENTS/CHANGES/REASONS/AREAS OF CONCERN: My signature below indicates that I have reviewed the Health Services and Behavior Support Treatment Reports. I have reviewed y recommendations, as well as the consequences to the individual for not following my recommendations with all parties attending this Physician's Printed Name, Signature and Date: Clinician: Signature, Title and Date:



Individual's Consent for Psychotropic Medication: Signature and Date:

Medical Decision-Maker's consent: Signature and Date: